(Enclosure 7)

HFP/C-CHIP Vision Benefits and Co-Payments for:

Name

Please fill in name and the C-CHIP shaded columns

HFP Vision Benefit	**HFP Copay for Dental Benefit**	**C-CHIP Dental Benefit Provided (yes/no)**	**C-CHIP Copay for Dental Benefit**
Examinations	$5		$
Frames and Lenses	$5		$
Contact Lenses			
Necessary	$0		$
Elective	Allowance		$
Low Vision Benefits			
Supplemental testing	$0		$
Supplemental care	$5		$